



New Patient Information

Craig Healy, DDS

Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____
Address (Street, City, State, ZIP) _____
Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
Insured's name _____ Relationship to patient _____
Date of birth _____ Insured's social security no. _____
Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____
Address (Street, City, State, ZIP) _____
Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____
Insured's name _____ Relationship to patient _____
Date of birth _____ Insured's social security no. _____
Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Person Financially Responsible for Account

Name _____ Relationship to patient _____
Social security no. _____ Phone () - _____
Driver's license no. _____ Date of birth _____
Address (Street, City, State, ZIP) _____
Employer _____ Work phone () - _____
Preferred payment method: ☐ Cash ☐ Credit Card ☐ Check
Visa/MC/AMEX no. _____ Exp. date _____
If patient is a minor, name of parent or legal guardian and relationship _____
Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ Date _____

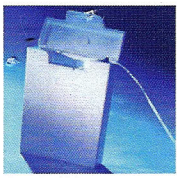
Person to contact in case of emergency

Name _____ Relationship _____
City _____ State _____ Cell phone _____
Home phone _____ Work phone _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____



New Patient Information

Craig Healy, DDS

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone () - Work phone () - Cell phone () -

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____

Fax () - E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone () - Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone () -

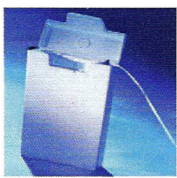
Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No



Today's date _____

Patient Number _____

1. Do you love the way your smile looks? ☐ Yes ☐ No

2. Do you feel comfortable showing your teeth when you laugh or smile? ☐ Yes ☐ No

3. If you could change anything about your smile, it would be (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Color of your teeth | <input type="checkbox"/> Too much or too little of teeth show when you smile | <input type="checkbox"/> Gaps between your teeth |
| <input type="checkbox"/> Size/Shape of your teeth | <input type="checkbox"/> Too much or too little of gum shows when you smile | <input type="checkbox"/> Alignment of your teeth |
| <input type="checkbox"/> Other: _____ | | |

4. Do you have (check all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sensitive or receding gums | <input type="checkbox"/> Worn/broken/chipped teeth | <input type="checkbox"/> Old or discolored fillings | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Old crowns that have dark edges at the top | <input type="checkbox"/> Other: _____ | | |

5. In your line of work or lifestyle, do you (check all that apply):

- | | | | |
|--|---------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Visit businesses or clients | <input type="checkbox"/> Travel | <input type="checkbox"/> Speak publicly | <input type="checkbox"/> Other: _____ |
|--|---------------------------------|---|---------------------------------------|

6. If you had a smile makeover do you think you'd feel (check all that apply):

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> More confident | <input type="checkbox"/> More optimistic | <input type="checkbox"/> Healthier |
| <input type="checkbox"/> Just OK | <input type="checkbox"/> No different | <input type="checkbox"/> Other: _____ |

7. Do you or someone in your family have issues with any of the following (check all that apply):

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Chronic bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Other: _____ | | |

We'd like to know more about you so we can better serve you!

8. Do you prefer appointments in the (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Early morning | <input type="checkbox"/> Early afternoon | <input type="checkbox"/> No preference |
| <input type="checkbox"/> Late morning | <input type="checkbox"/> Late afternoon | <input type="checkbox"/> Other: _____ |

9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

10. What type(s) of music do you enjoy? (check all that apply)

- | | | | |
|---|------------------------------------|-------------------------------|---------------------------------------|
| <input type="checkbox"/> Easy Listening | <input type="checkbox"/> Classical | <input type="checkbox"/> Rock | <input type="checkbox"/> Hip-Hop/Rap |
| <input type="checkbox"/> Jazz | <input type="checkbox"/> Country | <input type="checkbox"/> R&B | <input type="checkbox"/> Other: _____ |

11. What are your favorite hobbies or activities?

12. Do you have children and grandchildren? If so, please list their names and ages.

13. Is there anything else that you want our office to know about you that will help us to serve you better?



Have you ever had:

Periodontal disease/gum treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Discomfort in your jaw joint (TMJ/TMD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Orthodontics treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Your teeth ground or bite adjusted	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Oral surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Serious injury to the mouth or head	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A bite plate or mouth guard	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain _____

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No Do you use alcohol or any other controlled substance? ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had or have at present:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies or Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness/Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric/	
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Bones/Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart (Surgery, Disease,		Rheumatic/Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Attack)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles/Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease/Traits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer/Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia/Abnormal		Snoring/Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems/ Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A B C (circle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	High or Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized for Any Reason	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diet (Special/Restricted)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease/STD	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any serious medical condition(s) that you have ever had not listed above: _____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sedatives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jewelry/Metals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthetics (i.e. Novocaine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tetracycline	<input type="checkbox"/> Yes <input type="checkbox"/> No
Erythromycin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin or Other Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	

Patient signature _____